2. Unless adequate and current documentation in the following areas has been filed previously with the department, authenticated copies of the following documents must be submitted with the cost reports: authenticated copies of all leases related to the activities of the facility; all management contracts, all contracts with consultants; federal and state income tax returns for the fiscal year; and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.

3. Adequate documentation for all line items on the uniform cost reports must be maintained by the facility and must be submitted to the department upon request.

4. If a cost report is more than ten (10) days past due, payment shall be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's Medicaid participation agreement and if terminated, retain all payments which have been withheld pursuant to this provision.

5. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership or termination of participation in the Medicaid Program, the division will withhold all remaining payments from the selling provider until the cost report is filed. The fully completed cost report with all required attachments and documentation is due the first day of the sixth month after the date of change of control, ownership or termination. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.

(B) Certification of Cost Reports.

1. The accuracy and validity of any cost report must be certified. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make the certification and will furnish proof of the authorization): an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report must also be notarized by a licensed notary public.

2. Certification statement.

Form of Certification

Misrepresentation or falsifications of any information contained in this report may be punishable by fine, imprisonment, or both, under state or federal law.

Certification by officer or administrator of provider:

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by _____ (Provider's name(s) and number(s)) for the cost report period beginning,_____, 19_____ and ending _____, 19_____, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

_____ _____ _____
(Signature) (Title) (Date)

(C) Adequacy of Records.

1. The provider must make available to the department or its duly authorized agent, including federal agents from Health and Human Services (HHS), at all reasonable times, the records as are necessary to permit review and audit of provider's cost reports. Failure to do so may lead to sanctions stated in section (8) of this rule or other sanctions available in section (9) of this rule.

2. All records associated with the preparation and documentation of the data associated with the cost report must be retained for seven (7) years from the cost report filing date.

(D) Accounting Basis.

1. The cost report submitted must be based on the accrual basis of accounting.

2. Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods, provided appropriate treatment of capital expenditures is made.

(E) Audits.

1. Cost reports shall be based upon the provider's financial and statistical records which must be capable of verification by audit.

2. If the provider has included the cost of a certified audit of the facility as an allowable cost item to the plan, a copy of that audit report and accompanying letter shall be submitted without deletions.

3. The annual cost report for the fiscal year of the provider may be subject to audit by the Department of Social Services or its contracted agents. Twelve (12)-month cost reports for new construction facilities required to be submitted under section (4) of this rule may be audited by the department or its contracted agents prior to establishment of a permanent rate.

4. The department will conduct a desk review of all cost reports after submission by the provider and shall provide for on-site audits of facilities wherever cost variances or exceptions are noted by their personnel.

5. The department shall retain the annual cost report and any working papers relating to the audits of those cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

6. Those providers having an annual Title XIX bed-day ratio on total bed days or certified beds of greater than sixty percent (60%) or an annual Title XIX payment of two hundred thousand dollars ($200,000) or more, or both, shall be required, for at least the first two (2) fiscal years of participation in the plan, to have an annual audit of their financial records by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmations of accounts receivable and accounts payable are not required by the plan. For the purposes of the paragraph, the Department of Social Services will only accept an unqualified opinion from a certified public accounting firm. A copy of the audit report must be submitted to the department to support the annual cost report of the facility.

(9) Sanctions and Overpayments.

(A) Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 and other federal or state statutes and regulations.

(B) In the case of overpayments to providers based on, but not limited to, field or audit findings or determinations based on a comprehensive operational review of the facility, the provider shall repay the overpayment in accordance with the provisions as set forth in 13 CSR 70-3.030.

(10) Exceptions.

(A) For those Medicaid-eligible recipient-patients who have concurrent Medicare Part A skilled nursing facilities benefits available, Missouri Medical Assistance Program reimbursement for covered days of stay in a qualified facility will be based on the coinsurance as may be imposed under the Medicare Program.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided services of fewer than one thousand (1,000) patient days for Missouri Title XIX recipients, the reimbursement rate shall be the rate paid for comparable services and level-of-care by the state in which the provider is located; and

2. For providers which provide services of one thousand (1,000) or more patient days for Missouri Title XIX recipients, the reimbursement rate shall be the lower of--

A. The rate paid for comparable services and level-of-care by the state in which the provider is located; or

B. The rate calculated in sections (4) and (6) of this rule.

(11) Payment Assurance.

(A) The state will pay each provider, which furnished the services in accordance with the requirements of the state plan, the amount determined for services furnished by the provider according to the standards and methods set forth in these rules.

(B) Where third-party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Service. Procedures for remitting third-party payments are provided in the Missouri Medical Assistance Program provider manuals.

(12) Provider Participation. Payments made in accordance with the standards and methods described in this rule are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive medical care and services included in the state plan at least to the extent these services are available to the general public.

(13) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full for covered services rendered to Medicaid recipients, the amount paid in accordance with these rules and applicable copayments.

(14) Plan Evaluation. Documentation will be maintained to effectively monitor and evaluate experience during administration of this rule.

APPENDIX A
Routine Covered
Medical Supplies and Services

ABD Pads
A & D Ointment
Adhesive Tape
Aerosol Inhalators, Self-Contained
Aerosol, Other Types
Air Mattresses
Air P.R. Mattresses
Airway Oral
Alcohol
Alcohol Plasters
Alcohol Sponges
Antacids, Nonlegend
Applicators, Cotton-Tipped
Applicators, Swab-Eez
Aquamatic K Pads (water-heated pad)
Arm Slings
Asepto Syringes
Baby Powder
Bandages
Bandages (elastic or cohesive)
Bandaids
Basins
Bed Frame Equipment (for certain immobilized bed patients)
Bed Rails
Bedpan, Fracture
Bedpan, Regular
Bedside Tissues
Benzoin
Bibs
Bottle, Specimen

Canes
Cannula Nasal
Catheter Indwelling
Catheter Plugs
Catheter Trays
Catheter (any size)
Colostomy Bags
Composite Pads
Cotton Balls
Crutches
Customized Crutches, Canes and Wheelchairs
Decubitus Ulcer Pads
Deodorants
Disposable Underpads
Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets
Drainage Tubes
Dressing Tray
Dressings (all)
Drugs, Stock (excluding Insulin)
Enema Can
Enema Soap
Enema Supplies
Enema Unit
Enemas
Equipment and Supplies for Diabetic
Urine Testing
Eye Pads
Feeding Tubes
Female Urinal
Flotation Mattress or Biowave Mattress
Flotation Pads, Turning Frames, or both
Folding Foot Cradle

Gastric Feeding Unit
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hand-Feeding
Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine
Ice Bags
Incontinency Care
Incontinency Pads and Pants
Infusion Arm Boards
Inhalation Therapy Supplies
Intermittent Positive Pressure Breathing Machine (IPPB)
Invalid Ring
Irrigation Bulbs
Irrigation Trays
I.V. Trays
Jelly Lubricating
Laxatives, Nonlegend
Lines, Extra
Lotion, Soap and Oil
Male Urinal
Massages (by nurses)
Medical Social Services
Medicine Cups
Medicine Dropper
Merthiolate Aerosol
Mouthwashes
Nasal Cannula
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gastric Tubes
Nasal Tube Feeding
Nebulizer and Replacement Kit
Needles (hypodermic, scalp, vein)
Needles (various sizes)

Nonallergic Tape
Nursing Services (all) regardless of level including the administration of oxygen and restorative nursing care
Nursing Supplies and Dressing (other than items of personal comfort or cosmetic)
Overhead Trapeze Equipment
Oxygen Equipment (such as IPPB machines and oxygen tents)
Oxygen Mask
Pads
Peroxide
Pitcher
Plastic Bib
Pump (aspiration and suction)
Restraints
Room and Board (semiprivate or private if necessitated by a medical or social condition)
Sand Bags
Scalpel
Sheepskin
Special Diets
Specimen Cups
Sponges
Steam Vaporizer
Sterile Pads
Stomach Tubes
Stool Softeners, Nonlegend
Suction Catheter
Suction Machines
Suction Tube
Surgical Dressings (including sterile sponges)
Surgical Pads
Surgical Tape
Suture Removal Kit
Suture Trays

Syringes (all sizes)
Syringes, Disposable
Tape (for laboratory test)
Tape (nonallergic or butterfly)
Testing Sets and Refills (S & A)
Tongue Depressors
Tracheostomy Sponges
Tray Service
Tubing I.V. Trays, Blood Infusion Set, I.V. Tubing
Underpads
Urinary Drainage Tube
Urinary Tube and Bottle
Urological Solutions
Vitamins, Nonlegend
Walkers
Water Pitchers
Wheelchairs

Retrospective Reimbursement Plan for State-Operated Facilities for ICF/MR Services

(1) Objectives. The retrospective rate plan described in this rule shall apply to state-operated intermediate care facility/mentally retarded (ICF/MR) facilities for dates of service on and after March 1, 1990, and the objective of this plan is to provide reimbursement of allowable cost.

(2) General Principles. The Missouri Medical Assistance program shall reimburse qualified providers of ICF/MR services based solely on the individual Medicaid recipient's days of care (within benefit limitations) multiplied by the facility's Title XIX per-diem rate less any payments made by recipients as described in sections (4) and (5).

(3) Definitions.

(A) Allowable cost areas. Those cost areas which are allowable for allocation to the Medicaid program based upon the principles established in this plan. The allowability of cost areas not specifically addressed in this plan will be based upon criteria of the Medicare Provider Reimbursement Manual (HIM-15) and section (7) of this rule.

(B) Cost report. The cost report shall detail the cost of rendering covered services for the fiscal reporting period. Providers must file the cost report on forms provided by and in accordance with the procedures of the department.

(C) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(D) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(E) Division. The division, unless otherwise specified, refers to the Division of Medical Services.

(F) Effective date. The plan effective date shall be for services furnished on and after March 1, 1990.

(G) ICF/MR. State-operated facilities certified to provide intermediate care for the mentally retarded under the Title XIX program.

(H) Medicare rate. This is the allowable cost of care permitted by Medicare standards and principles of reimbursement (42 CFR part 405).

(I) New construction. Newly built facilities or parts for which an approved Certificate of Need (CON) or applicable waivers were obtained and which were newly completed and operational on or after March 1, 1990.

(J) Patient days. Patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (6) of this rule, the day of discharge being counted only when the patient was admitted the same day. A census log shall be maintained in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a recipient is away from the facility on a facility-sponsored group trip and remains under the supervision and care of facility personnel.

(K) Providers. A provider under the Retrospective Reimbursement Plan is a state-operated ICF/MR facility with a valid participation agreement in effect on or after February 28, 1990, with the Missouri Department of Social Services for the purpose of providing long-term care (LTC) services to Title XIX-eligible recipients.

(L) Reasonable and adequate reimbursement. Reimbursement levels which meet the needs of an efficiently and economically operated facility.

(4) Interim Rate.

(A) For service dates beginning March 1, 1990 through and including June 30, 1991, each provider shall be assigned an interim per-diem rate for reimbursement under the Missouri Medicaid program. The interim per-diem rate will be based on the provider's fiscal year (FY)-89 desk-reviewed allowable costs inflated forward on the basis of the historical rate of change. This rate of change shall be thirty-five percent (35%) of the following amount: the percentage increase between the FY-87 weighted mean allowable cost per patient day for all state-operated facilities (WMACPPDSOF) and the FY-89 WMACPPDSOF annualized by dividing by two (2).

Example

FY-87 WMACPPDSOF $128.06
FY-89 WMACPPDSOF $161.47

Percent of Change
($161.47 - $128.06) ÷ $128.06 = 26.09%

Annualized Percent of Change ($26.09 ÷ 2) = 13.04%

35% of Annualized Percent of Change
(13.04% x 35%) = 4.57%

Facility FY-89 Allowable Cost $24,220,500

Facility FY-89 Patient Days 150,000

Inflated Cost ($24,220,500 104.57%) = $25,327,376

Interim Rate ($25,327,376 ÷ 150,000) = $168.85

(B) For service dates beginning July 1, 1991 and annually after that, each provider shall be assigned an interim per-diem rate based on the provider's second prior year desk-reviewed allowable costs inflated forward on the basis of the historical rate of change. This rate of change shall be fifty percent (50%) of the following amount: the percentage increase between the fourth prior year WMACPPDSOF and the second prior year WMACPPDSOF annualized by dividing by two (2). For example with the July 1, 1991 interim rate, the fourth prior year is the facility fiscal year ending June 30, 1988, and the second prior year is the facility fiscal year ending June 30, 1990.

Example

FY-88 WMACPPDSOF	$160
FY-90 WMACPPDSOF	$180

Percent of Change ($180 - $160) ÷ $160 =12.50%

Annualized Percent of Change ($12.50 ÷ 2) = 6.25%

50% of Annualized Percent of Change
(6.25% x 50%) = 3.13%

Facility FY-90 Allowable Cost $27,000,000

Facility FY-90 Patient Days 150,000

Inflated Cost ($27,000,000 103.13%) = $27,845,100

Interim Rate ($27,845,100 ÷ 150,000) = $185.63

(C) In the case of newly constructed state-operated ICF/MR facilities or existing facilities not previously certified to participate in the Title XIX Program entering the Missouri Medicaid Program after February 28, 1990, the facilities shall have an interim rate based on one hundred twenty-five percent (125%) of the weighted mean rate of all providers for the month prior to entering the Missouri Medicaid Program until the time a second prior year cost report is available, at which time the provisions of subsection (4)(B) will apply.

Example

Weighted Mean Rate of All Providers (7/01/91) $160

Interim Rate Effective (8/01/91) ($160 x 125%) = $200

(D) When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's interim rate at the discretion of the division may be both retroactively and prospectively adjusted if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a different interim rate than the facility would have received in the absence of that information.

(5) Retroactive Adjustments.

(A) The division shall desk review the Medicaid cost reports for each facility and shall determine the facility's allowable cost per patient day. This shall be the final per-diem rate for the service dates covered by the cost report. A payment adjustment will be made equal to the difference between the final per-diem rate and the interim per-diem rate multiplied by the Medicaid days corresponding to the service dates covered by the interim per-diem rate. For the period March 1, 1990 through June 30, 1990, the full facility Fiscal Year 1990 Medicaid cost report will be used to establish the final per-diem rate for payment adjustment purposes.

(B) When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's final rate at the discretion of the division may be both retroactively and prospectively adjusted if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a different final rate than the facility would have received in the absence of that information.

(6) Covered Services and Supplies. ICF/MR services and supplies covered by the per-diem reimbursement rate under this rule, and which must be provided, are found in 42 CFR 442.100--442.516 and include, among other services, the regular room, dietary and nursing services or any other services that are required for standards of participation or certification, also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

(A) All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service and enemas;

(B) Items which are furnished routinely and relatively uniformly to all recipients, for example, gowns, water pitchers, soap, basins and bed pans;

(C) Items such as alcohol, applicators, cotton balls, bandaids and tongue depressors;

(D) All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners and nonlegend vitamins. All nonlegend drugs in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; all must be provided as needed within the existing per-diem rate;

(E) Items which are utilized by individual recipients but which are reusable and expected to be available such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable, nondepreciable medical equipment;

(F) Additional items as specified in the appendix to this plan when required by the patient;

(G) Special dietary supplements used for tube feeding or oral feeding such as elemental high nitrogen diet, including dietary supplements written as a prescription item by a physician;

(H) All laundry services including personal laundry;

(I) All general personal care services which are furnished routinely and relatively uniformly to all recipients for their personal cleanliness and appearance shall be covered services; for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service;

(J) All consultative services as required by state or federal law or rule or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report. Failure to do so will result in the penalties specified in section (9) of this rule;

(K) Semiprivate room and board and private room and board when necessary to isolate a recipient due to a medical or social condition, such as contagious infection, irrational loud speech and the like. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service and a Medicaid recipient or responsible party may pay the difference between a facility's semiprivate charge and its charge for a private room. Medicaid recipients may not be placed in private rooms and charged any additional amount above the facility's Medicaid per diem unless the recipient or responsible party specifically requests in writing a private room prior to placement in a private room and acknowledges that an additional amount not payable by Medicaid will be charged for a private room;

(L) Twelve (12) days per any period of six (6) consecutive months during which a recipient is on a temporary leave of absence from the facility. These temporary leave of absence days specifically must be provided for in the recipient's plan of care. Periods of time during which a recipient is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence; and

(M) Days when recipients are away from the facility overnight on facility-sponsored group trips under the continuing supervision and care of facility personnel.

(7) Allowable Cost Areas.

(A) Covered Services and Supplies as Defined in Section (6) of This Plan.

(B) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings and equipment which are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight-line method of depreciation from the date initially put into service.

3. The basis of assets shall be the lower of the book value of the provider, fair market value at the time of acquisition or the recognized Internal Revenue Service (IRS) tax basis. Donated assets will be allowed basis to the extent of recognition of income resulting from the donation of the

asset. Should a dispute arise between a provider and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the Medicaid Program and the facility in ratio to Medicaid recipient reimbursable patient days to total patient days.

4. Allowable methods of depreciation shall be limited to the straight-line method. The depreciation method used for an asset under the Medicaid Program need not correspond to the method used by a provider for non-Medicaid purposes; however, useful life shall be in accordance with the American Hospital Association's Guidelines. Component part depreciation is optional and allowable under this rule.

5. Historical cost is the cost incurred by the provider in acquiring the asset and preparing it for use except as provided in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees and related legal fees. Where a provider has elected to expense certain items such as interest and taxes during construction, the historical cost basis for Medicaid depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this rule, any asset costing less than five hundred dollars ($500) or having a useful life of one (1) year or less may be expensed and not capitalized at the option of the provider.

6. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of undepreciated cost basis of the traded asset plus the cash paid.

7. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if the capital expenditures have not received approved CON or waiver.

8. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this plan.

(C) Interest and Finance Costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short-term. This is usually for purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and capital improvements and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost item, interest (including finance charges, prepaid costs and discounts) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claims and necessary and proper for the operation, maintenance or acquisition of the provider's facilities.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made and provided further the department shall not reimburse for interest and finance charges any amount in excess of the prime rate current at the time the loan was obtained.

7. Income from a provider's qualified retirement fund shall be excluded in consideration of the per-diem rate.

8. A provider shall amortize finance charges, prepaid interest and discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

9. Usual and customary costs excluding finder's fees incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

10. Usual and customary costs shall be limited to the lender's title and recording fees, appraisal fees, legal fees, escrow fees and closing costs.

11. Interest expense resulting from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost item if the expenditure fails to comply with other federal or state requirements that promulgate a limitation on reimbursement for capital expenditures, such as CON.

(D) Rental and Leases.

1. Rental and leases of land, buildings, furnishings and equipment are allowable cost areas; provided, that the rented items are necessary and not in essence a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those which are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those which are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and lease amounts, except in the case of related parties which is subject to other provisions of this plan, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to CON approval must have that approval before a rate is determined.

(E) Taxes. Taxes levied on or incurred by providers shall be allowable cost areas with the exceptions of the following items:

1. Federal, state or local income and excess profit taxes including any interest and penalties paid;

2. Taxes in connection with financing, refinancing or refunding operations such as taxes on the issuance of bond, property transfer, issuance or transfer of stocks;

3. Taxes for which exemptions are available to the provider;

4. Special assessments on land which represent capital improvements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid;

5. Taxes on property which is not a part of the operation of the provider; and

6. Taxes which are levied against a resident and collected and remitted by the provider.

(F) Value of Services of Employees.

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers, such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations, shall not be included as an allowable cost area, as the services traditionally have been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost area, provided that the services are not of a religious nature. An example of an allowable cost area under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. Costs for wardrobe and similar items likewise are considered nonallowable.